BUCKEYE HILLS CAREER CENTER

GALLIA-JACKSON-VINTON JOINT VOCATIONAL SCHOOL DISTRICT
P.O. Box 157, Rio Grande, Ohio 45674 | 740.245.5334 | BuckeyeHills.net

Request for Medical Information for Student Cellular Usage

Acceptable Healthcare Providers

The following licensed healthcare providers may verify a medical exemption:

- **Treating Physicians (MD/DO)** – Authorized to provide written verification without limitation.
- **Treating Nurse Practitioners (NPs)** – Authorized to provide written verification when acting within their professional scope of practice under Ohio law (ORC Chapter 4723). This includes diagnosing and managing medical conditions such as asthma, diabetes, or other chronic health needs that require device monitoring.
- **Treating Other Licensed Providers** – Documentation from physician assistants or specialists may also be accepted if consistent with state law and district policy.

Information Requests

To **potentially** qualify for an exemption, the written documentation must:

1. Identify the student by name and date of birth.

   Student Name: _____ Date of Birth:_____

2. Specify the medical condition requiring the use of a cell phone or similar device.

Medical Condition:

3. Clearly state the **purpose, frequency, and context** in which the device is required (e.g., blood glucose monitoring, seizure alerts, emergency communication).

Purpose:
Frequency:
Context:

4. Must be signed and dated by the verifying **treating** healthcare provider (physician, nurse practitioner, or other authorized provider).

Physicians (MD/DO) – Authorized to provide written verification without limitation.

Signature:_____ Date: _____

Print Name: _____

Nurse Practitioners (NPs) – Authorized to provide written verification when acting within their professional scope of practice under Ohio law (ORC Chapter 4723). This includes diagnosing and managing medical conditions such as asthma, diabetes, or other chronic health needs that require device monitoring.

Signature:_____ Date:_____

Print Name: _____

Other Licensed Providers – Documentation from physician assistants or specialists may also be accepted if consistent with state law and district policy.

Signature:_____ Date:

Print Name: _____

District Implementation

- **Review Process:** The documentation will be submitted to Jared Taylor, Dean of Student Services, for review and verification.
- **Care Plan Integration:** Upon approval, the exemption **may** be incorporated into the student's **Individual Health Care Plan (IHCP)** or **Section 504/IEP**, as appropriate.
- **Collaboration:** The school nurse and health services team will collaborate with the family and the verifying provider to ensure appropriate use of the device.
- **Confidentiality:** All medical documentation and plans will be maintained in compliance with FERPA and HIPAA regulations.

Limitations and Conditions

- Exempted use is **strictly limited to medical necessity** and must align with the guidance provided by the healthcare provider.
- **The student may not use the device for personal, social, or non-medical purposes during instructional hours.**

The district reserves the right to review the exemption and request updated medical documentation periodically.

School USE ONLY
Date Received: Dean of Student Services (Signature): School Nurse (Signature): Notes: